Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SPORTS REHABILITATION SPECIALISTS 1901 COOPER STREET FORT WORTH TX 76104	MFDR Tracking #: M4-09-3874-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: CITY OF FORT WORTH Box #: 04	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…CCS Consultants has denied the claims due to '198A Precertification/authorization exceeded'. On the pre-authorizations letter #AP145355 we received from Argus Services clearly states the number of visits authorized and the date of 8/08/08 thru 9/05/08. We have appeal the dates of service 8/26/08, 8/27/08, 8/29/08 to CCS Consultants on October 22, 2008 and they responded with '193 Original payment decision is being maintained'. Patient was here on 8/12/08, 8/13/08, 8/15/08, 8/19/08, 8/20/08, 8/22/08, 8/26/08, 8/27/08, and 8/29/08. We feel that we did use the 9 visits within the time frame given by Argus Services and communicate that to CCS Consultants…"

Amount in Dispute: $840.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pre-authorization letter AP145355 dated August 8, 2008 allowed for physical therapy up to four units. Therefore, an additional allowance is recommended up to sixty minutes for each of the dates of service. Since the medical records for August 29, 2008 did not document the actual measurements of the testing, no allowance is recommended for code 95851."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
08/26/2008	97110-GP x 3 units	Pre-authorization Obtained for 2 units only. Exceeded Pre-Authorization Approval by 1 unit. MAR is $37.15 x 2 units = $74.30	$135.00	$74.30
08/26/2008	97140-GP x 2 units	Pre-authorization Obtained. MAR is $34.50 x 2 units = $69.00	$100.00	$69.00
08/26/2008	G0283-GP	Exceeded Pre-Authorization Approval units this DOS.	$20.00	$0.00
08/27/2008	97110-GP x 3 units	Pre-authorization Obtained for 2 units only. Exceeded Pre-Authorization Approval by 1 unit. MAR is $37.15 x 2 units = $74.30	$180.00	$74.30
08/27/2008	97140-GP x 2 units	Pre-authorization Obtained for 2 units only. MAR is $34.50 x 2 units = $69.00	$100.00	$69.00
08/27/2008	G0283-GP	Exceeded Pre-Authorization Approval units this DOS.	$20.00	$0.00
08/29/2008	95851-59-GP	Exceeded Pre-Authorization Approval units this DOS. Documentation does not support service billed.	$50.00	$0.00
08/29/2008	97110-GP x 3 units	Pre-authorization Obtained for 2 units only. Exceeded Pre-Authorization Approval by 1 unit. MAR is $37.15 x 2 units = $74.30	$135.00	$74.30
08/29/2008	97140-GP x 2 units	Pre-authorization Obtained for 2 units only.	$100.00	$69.00

		MAR is $34.50 x 2 units = $69.00		
			Total Due:	$429.90

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

The Division contacted the requestor's representative, Hilda Moreno on 01/14/09, to ascertain if additional payment had been received from respondent. Per requestor's representative, Hilda Moreno, payment has not been received as of 01/14/09.

The Division contacted the respondent's representative, Michelle Creech on 01/16/09, to ascertain if additional payment had been made to the respondent. Per respondent's representative, Michelle Creech, their bill audit did not recommend any allowance as stated in the respondent's position summary.

The requestor's representative, Hilda Moreno contacted the Division on 03/08/2011 indicating that no additional reimbursement has been paid.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 10/01/2008 noted claim reduction codes:
   - 198A — Precertification/authorization exceeded. *Service was provided after the specified time to complete the treatment.*
   - 97H — The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*

   Explanation of benefits dated 11/11/2008 noted claim reduction codes:
   - 193 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 198A — Precertification/authorization exceeded. *Service was provided after the specified time to complete the treatment.*

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Tex. Admin. Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code Section 413.014(b) states "the insurance carrier is not liable for those specified treatments and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission." 28 TAC §134.600(c)(1)(B) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care." 28 TAC §134.600(p)(5) requires preauthorization for "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning." A review of the preauthorization letter dated 08/08/08 identifies that physical therapy received authorization for 9 sessions to include four units of any combination of 95851, 97110, 97140, G0283 or 97035 per session with a start date of 08/08/08 and continuing through end date of 09/05/08 under authorization number AP145355. The authorized physical therapy date range does include the disputed dates of service.

2. Division rule at 28 TAC §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values of weights included its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." Review of box 32 of the medical bills finds the disputed services were rendered in Fort Worth, Texas, ZIP code 76104, which is located in Tarrant County. The applicable Division Fee Guideline for this medical service is set forth in Division rule at 28 TAC §134.203(c)(1).

   Pursuant to Division Rule at 28 Texas Administrative Code Section 134.203(b), CPT code 97110 is not considered to be a component procedure of any other CPT code billed on the same date of service. The Maximum Allowable Reimbursement for CPT code 97110-GP x 3 units rendered in Fort Worth, Texas on the disputed dates of service 08/26/09, 08/27/08 and 08/29/08 is $26.78 (Medicare fee amount) multiplied by $52.83 (Workers' Compensation conversion factor) divided by 38.087 (Medicare conversion factor) = $37.15. The requestor exceeded the pre-authorization approval by 1 unit for each date of service. Reimbursement is recommended in the amount of $37.15 x 2 units = $74.30 x 3 dates of service = $222.90.

   Pursuant to Division rule at 28 Texas Administrative Code Section 134.203(b), CPT code 97110 is not considered to be a component procedure of any other CPT code billed on the same date of service. The Maximum Allowable Reimbursement for CPT code 97140-GP x 2 units rendered in Fort Worth, Texas on the disputed dates of service 08/26/09, 08/27/08 and 08/29/08 is $24.87 (Medicare fee amount) multiplied by $52.83 (Workers' Compensation conversion factor) divided by 38.087 (Medicare conversion factor) = $34.50. Reimbursement is recommended in the amount of $34.50 x 2 units = $69.00 x 3 dates of service = $207.00.

   The Maximum Allowable Reimbursement for CPT code G0283 rendered in Fort Worth, Texas on the disputed dates of service 08/26/09, 08/27/08 and 08/29/08 is $10.94 (Medicare fee amount) multiplied by $52.83 (Workers' Compensation conversion factor) divided by 38.087 (Medicare conversion factor) = $15.17. However, the requestor exceeded the preauthorized units for each date of service. Reimbursement is not recommended.

   The Maximum Allowable Reimbursement for CPT code 95851-59-GP rendered in Fort Worth, Texas on the disputed dates of service 08/26/09, 08/27/08 and 08/29/08 is $17.21 (Medicare fee amount) multiplied by $52.83 (Workers' Compensation conversion factor) divided by 38.087 (Medicare conversion factor) = $23.87. However, the requestor exceeded the preauthorized units for each date of service. Additionally, documentation does not support service billed. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $429.90.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $429.90 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**08/31/2011** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.